EXECUTIVE SUMMARY

The Impact of the 2009 Affordable Health Choices Act

From the Senate Committee on Health, Education, Labor and Pensions (HELP)

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Completed by:

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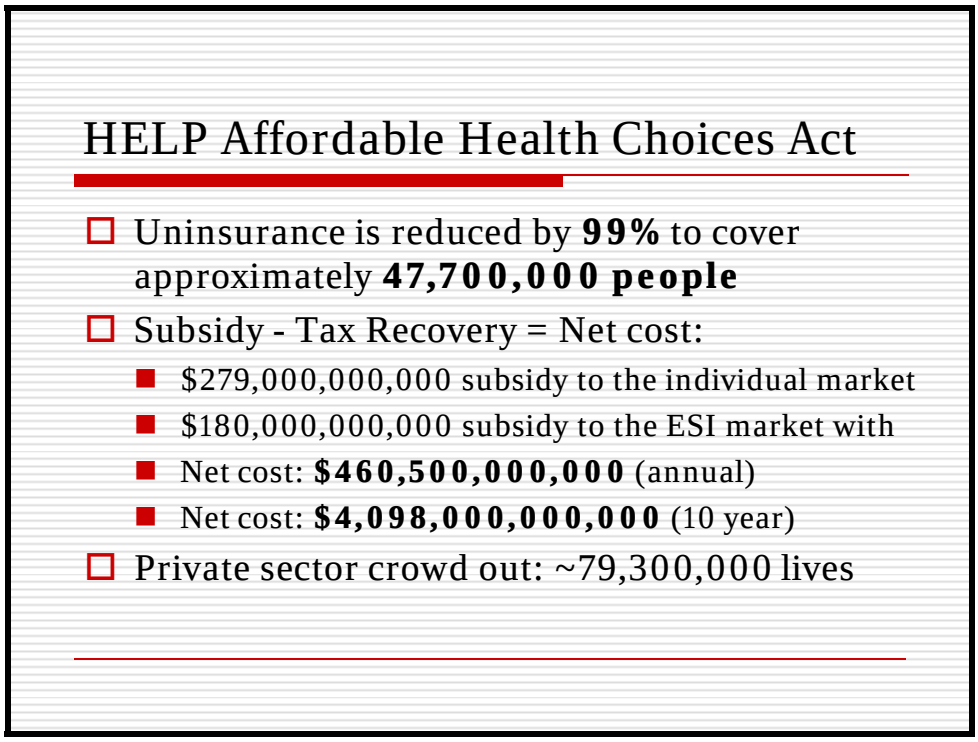
2009 Affordable Health Choices Act

Independent Assessment by HSI Network LLC
For Public Dissemination

Summary Snapshot

The Senate Committee on Health, Education, Labor and Pensions (HELP) have proposed a health reform bill called the Affordable Health Choice Act (AHC) that seeks to reduce the number of uninsured and increase health system efficiency and quality. The draft legislation was introduced on June 9th, 2009. The proposal provided adequate information to suggest what the impact would be of AHC using the ARCOLA™ simulation model. AHC would include an individual mandate as well as a pay or plan provision. In addition, it would include a means-tested subsidy with premium supports available for those up to 500% of the federal poverty level. Public plan options in three tiers: Gold, Silver and Bronze are proposed in a structure similar to that of the Massachusetts Connector, except that it is called The Gateway. These public plan options would contain costs by reimbursing providers up to 10% above current reimbursement rates. There is no mention of removing the tax exclusion associated with employer sponsored health insurance. There is also no mention of changes to Medicare and Medicaid, other than fraud prevention, that could provide cost-savings for the coverage expansion proposed. Below, we summarize the impact of the proposed plan in terms of the reduction on uninsured, the 2010 cost, as well as the ten year cost of the plan in 2010 dollars.



The underlying simulation model used is ARCOLA™, a proprietary version of a health reform coverage and cost assessment analytic engine. A peer-reviewed presentation of the core model structure is summarized in the journal Health Affairs[1] and a longer version is available as a DHHS report at www.ehealthplan.org

Scoring Components

Major policy components considering for scoring:

- Employers would have to offer health insurance or pay a tax not as yet specified
- Individuals would have to be covered by a qualified plan or pay a tax
- Medicaid for everyone up to 150% of poverty
- Sliding scale subsidy from 150% to 500% of poverty
- The government would define a qualified plan with 3 levels of coverage: gold, silver and bronze. We assume the subsidy would be priced at the silver level of benefit design
- All plans must use modified community rating: premiums can vary only by geographic region (to be defined), family structure, actuarial value of benefits, and age (maximum 2:1 range).
- Public plan that pays Medicare rates +10%
- Small-employer tax subsidy

Summary

The plan lowers the uninsured significantly, to less than 1% of the population, but not without a cost of over four trillion dollars over 10 years. There are no provisions in the legislation to offset this course. Even if the most generous estimate of the employer sponsored tax exclusion ($300 billion per year, including collecting FICA contributions from employers) where used and combined with fraud estimates and block granting all of Medicaid (acute and long term care[2]), this would be a challenging proposal to finance with budget neutrality. Finally, the public plans will be quite successful in recruiting large numbers of Americans. They will also likely crowd out at 79 million individual contracts with existing private insurers.

[1] See Feldman, R., Parente, S.T. et al., "Health Savings Accounts: Early Evidence of National Take-up from the 2003 Medicare Modernization Act and Future Policy Proposals," Health Affairs, 24:6 (November/December, 2005), pp. 1582-1591.

[2] http://www.cbo.gov/ftpdocs/99xx/doc9925/12-18-HealthOptions.pdf, assume bigger $$ than acute care

Detailed Breakout of AHC Legislation Impact from ARCOLA™

		Affordable Health Choices Act Impact		
Individual Market	**Status Quo Population**	**Proposal Population**	**2010 Total Impact**	**Population Impact**
Insured	16,182,877	57,513,571	$279,903,791,139	11,572,054
Uninsured	41,843,646	501,918	0	-41,341,728
		Subtotal	$279,903,791,139	
Group Market				
Insured	162,665,411	168,980,727	$180,626,259,236	-70,763,315
Uninsured	6,773,521	443,524	$0	-6,329,997
		Subtotal	$180,626,259,236	
		Total	**$460,530,050,376**	
Total Market				
Insured	178,848,288	226,494,298	$460,530,050,376	
Uninsured	48,617,167	945,442	0	**-47,671,725**

2009 Affordable Health Choices Act
2010 Dollar Estimates by Plan Choices

Individual Market	**Status Quo Population**	**2010 Population**	**2010 Fiscal Impact**	**Delta**
HSA	6,764,409	8,837,503	$24,523,097,130	2,073,094
Public Gold	0	21,634	$38,352,668	
Public Silver	0	15,384,939	$85,340,451,551	
Public Bronze	0	14,352,067	$80,151,337,191	
PPO High	57,525	1,121,641	$7,691,906,410	1,064,116
PPO Low	9,009,693	6,569,646	$18,899,814,008	-2,440,047
PPO Medium	351,250	11,226,141	$63,258,832,181	10,874,891
Uninsured	41,843,646	501,918	$0	-41,341,728
			$279,903,791,139	
Group Market				
HMO	38,902,944	25,212,667	$18,220,965,760	-13,690,277
HRA	4,628,425	3,584,030	$2,636,475,136	-1,044,395
Employer-sponsored HSA	141,186	57,501	$43,016,344	-83,684
Opt-out HSA	277,905	2,261,246	$6,230,527,020	1,983,341
Public Gold	0	11,159,097	$4,940,047,142	
Public Silver	0	38,123,622	$47,241,576,558	
Public Bronze	0	27,795,913	$32,108,463,133	
Opt-out PPO Low	245,762	651,234	$398,087,278	405,472
PPO High	17,286,666	19,528,447	$26,951,344,787	2,241,781
PPO Low	2,023,263	996,385	$424,070,922	-1,026,878
PPO Medium	87,320,502	38,739,485	$41,431,685,157	-48,581,017
Turned Down - Other Private	11,838,759	871,099	$0	-10,967,659
Turned Down - No insurance	6,773,521	443,524	$0	-6,329,997
			$180,626,259,236	
		Total Subsidy:	$460,530,050,376	

ARCOLA™ Technical Documentation

The ARCOLA™ model is a national health policy impact micro-simulation model designed to estimate the impact of health policy proposals at federal and state levels. The model predicts individual adult responses to proposed policy changes and generalizes to the US population with respect to: 1) health insurance coverage and 2) financial impact of the proposed changes.

This model was first used for the Office of the Assistant Secretary (OASPE) of the Department of Health and Human Services (DHHS) to simulate the effect of the Medicare Modernization Act of 2003 (MMA) on take-up of high-deductible health plans in the individual health insurance market (Feldman, Parente, Abraham et al, 2005; Parente et al, Final Technical Report for DHHS Contract HHSP233200400573P, 2005). The model was later refined to incorporate the effect of prior health status on health plan choice – a necessary step if one wants to predict enrollment more accurately. The latest model also used insurance expenditures from actual claims data to refine premiums and then predict choices again with the new premiums. The model then iterates the choice model until premiums and choices converge, and then finds an equilibrium state. A subsequent change to the model permitted state-specific predictions of policy changes as well as total federal health policy impact.

Model Components & Data Sources

There are three major components to the ARCOLA™ model: 1) Model Estimation; 2) Choice Set Assignment and Prediction; and 3) Policy Simulation. Often, more than one database was required to complete the task. Integral to this analysis was the use of consumer directed health plan data from four large employers working with the study investigators.

The model estimation had several steps. As a first step, we pooled the data from the four employers offering CDHPs to estimate a conditional logistic plan choice model similar to our earlier work (Parente, Feldman and Christianson, 2004). In the second step we used the estimated choice-model coefficients to predict health plan choices for individuals in the MEPS-HC. In order to complete this step, it was necessary first to assign the number and types of health insurance choices that are available to each respondent in the MEPS-HC. For this purpose we turned to the smaller, but more-detailed MEPS Household Component-Insurance Component linked file, which contained the needed information. The third step was to populate the model with appropriate market-based premiums and benefit designs. The final step was to apply plan choice models coefficients to the MEPS data with premium information to get final estimates of take up and subsidy costs.